

BCAP Allergic Rhinitis in ADULTS guidance 2018

Diagnosis:

Ask the patient about:

- Triggers (seasonal, indoors/outdoors, work/school location)
- Relationship to potential triggers & impact on quality of life
- Pets or contact with animals
- Improvement of symptoms on weekends or holidays
- Drug history including use of: anti-hypertensives (inc. alpha & beta-blockers), aspirin & NSAIDs, oral contraceptives, topical sympathomimetics
- Any family history of rhinitis

Key symptoms & signs:

- Rhinorrhoea with yellow or green discharge
- Nasal blockage (consider nasal polyps or septal deviation)
- Nasal crusting (consider systemic inflammatory or granulomatous polyangiitis disorder)
- Bleeding (often associated with rhinitis but may be secondary to topical corticosteroid, consider malignancy if bleeding is unilateral)
- Hyposmia caused by nasal polyps
- Eye symptoms including red eye, lid swelling, and periorbital oedema
- Cough, wheeze, and breathlessness- asthma or bronchiectasis may also be present
- Snoring and sleep problems
- Sneezing and itching
- Repeated sniffing and nasal intonation of speech

Lifestyle Advice – ALL PATIENTS SHOULD BE GIVEN THIS ADVICE

- Allergen avoidance: Bedding to reduce exposure to house dust mite can be bought if necessary, frequent hoovering may also help. For seasonal allergens like pollen, minimise outdoor activity at peak pollen times (early morning, early evening, during mowing) and avoid going outside during or after thunderstorms. Keep windows closed at home & in the car and shower/wash hair after high exposure. Avoid drying washing outdoors when pollen levels are high. Wear sunglasses if ocular symptoms are problematic.
- Patients must understand the importance of adherence to regular therapy for rhinitis rather than PRN use.
- Smoking cessation advice should be given if the patient is a smoker & referral to cessation services

Refer in the following circumstances:

Refer to ENT specialist	Refer to allergy clinic
<ul style="list-style-type: none"> • Unilateral rhinorrhoea- may indicate cerebrospinal fluid leak • Unilateral nasal blockage- may indicate foreign body or tumour (URGENT referral is required) • Nasal crusting- may indicate granulomatosis or vasculitis • Septal perforation- may indicate granulomatous disease • If surgery may be required (for nasal blockage, nasal polyps, anatomical variations of the septum) 	<ul style="list-style-type: none"> • When treatment with a combination of antihistamine and inhaled nasal corticosteroid is ineffective • To consider immunotherapy in allergic rhinitis • When an allergic trigger is suspected & allergen avoidance could mitigate symptoms • If occupational rhinitis is suspected (also refer to an occupational health service) • If symptoms persist despite surgery (e.g. recurrent sinusitis or nasal polyps) • If there is chronic infective sinusitis lasting >3 months- this may indicate immune deficiency • If there is parental concern that persistent symptoms are affecting sleep or school performance

Allergic rhinitis treatment pathway

Full patient history and nasal examination. Allergen/irritant avoidance and smoking cessation advice PLUS:

MILD AND INTERMITTENT (Seasonal)

- No troublesome symptoms
- Completes normal daily activities
- No sleep disturbance
- Normal work and school

Treatment: Oral antihistamine

1st line: Cetirizine or Loratadine **Buy OTC**

Non-oral anti-histamine alternative on FP10 (POM):

- Azelastine (Rhinolast®) nasal spray (one spray in each nostril TWICE DAILY).

Superior to oral antihistamines (but more expensive) and no systemic adverse effects. Rapid onset of action.

EYE symptoms:

Oral antihistamines and intranasal agents may help to suppress ocular seasonal rhinoconjunctivitis symptoms.

Patient can purchase OTC:

- Sodium Cromoglycate 2% eye drops 13.5ml 1 to 2 drops QDS
- Olaptadine eye drops 1 drop BD for max 4 months

Pregnancy/breastfeeding:

Prescribe an intranasal corticosteroid. If not tolerated or additional treatment is required, prescribe an oral antihistamine (loratadine). **Use the lowest dose for the shortest possible duration.**

Nasal douching with normal saline can be used alternatively or in addition if necessary.

For further advice about treating allergic rhinitis in pregnancy see this reference:

<https://www.evidence.nhs.uk/search?q=%22Which+medicines+can+be+used+to+treat+intermittent+allergic+rhinitis+during+pregnancy%22>

MODERATE-SEVERE OR PERSISTENT (Perennial)

- Impaired daily activities
- Abnormal sleep, sleep disturbance
- Troublesome symptoms
- Problems caused at school/work

Treatment: Intranasal steroid (start at lower dose & increase if necessary).

Intranasal steroids are the most effective treatment for allergic rhinitis but their effect is not immediate and maximum relief can take days or weeks to be seen.

- If the predominant symptom is nasal blockage, use an intranasal steroid as per the table on the following page.
- If nasal polyps are present, use intranasal corticosteroids which are specifically licensed for this indication: Budesonide 64mcg spray, Mometasone 50mcg spray or Flixonase nasules (least cost effective choice). N.B. A short course of an oral steroid (30mg od for 7 days) may be needed initially to shrink large polyps.
- If the predominant symptom is sneezing or nasal discharge: Try an oral antihistamine (as per box to the left) or intranasal steroid (which is more effective).
- Advise patients to re-consult after 2-4 weeks if symptoms remain inadequately controlled.

Stepping up treatment if there are still residual symptoms:

- An oral antihistamine may be used with an intranasal steroid if the intranasal steroid is not completely resolving symptoms and is at maximum dose. Especially useful for persistent nasal itch, sneezing, rhinorrhoea or allergic conjunctivitis.
- Alternatively, try Dymista® (Fluticasone propionate plus azelastine) nasal spray. Remove any oral antihistamine if the patient is taking one.
- If this doesn't control symptoms, adding a nasal antimuscarinic drug such as ipratropium (Rinatec nasal spray 0.03%) might be of use.
- If nasal blockage is a problem, add an intranasal decongestant (e.g. ephedrine 0.5% or xylometazoline 0.1% nasal drops) for up to 7 days.
- If the patient also has asthma, a leukotriene antagonist such as oral montelukast may be helpful.

Treatment failure: REFER to specialist- see page 1

- For infection/structural problem
- For immunotherapy especially if symptoms are predominantly due to one allergen

BCAP Formulary options

Before issuing an NHS prescription, patients should be encouraged to self-treat their hayfever symptoms by taking actions to avoid contact with pollen as well as purchasing over the counter products from a pharmacy to reduce their symptoms.

Prices from Drug Tariff March 2018

Corticosteroid Nasal Spray- remind all hay fever sufferers to reduce the dose once symptoms are controlled

	Drug	Licensed Dosage (over 12 yrs- for children's doses see SPC)	Cost/pack	OTC or POM	One pack will last	Cost 28 days
1st	Mometasone Nasal spray 50mcg/dose PRESCRIBE GENERICALLY (Nasonex®) <i>Also licensed for nasal polyps</i>	Adults and children over 12: two sprays in each nostril once daily (total dose 200 micrograms). <i>NOTE: <1% systemic bioavailability</i>	£1.65 <i>if prescribed generically (140 doses)</i>	POM	35 days	£1.32
1st	Beclomethasone aqueous nasal spray (50mcg/dose) prescribed as Beconase® 200 dose <i>Do not prescribe as Beconase Hay fever 120 or Beconase Hayfever Relief</i>	Adults and children over 12: two sprays each nostril twice daily, reduce when symptoms controlled <i>NOTE: 44% systemic bioavailability</i> NB: OTC options are for over 18s only	£2.51 (200 doses)	POM/ P/GSL options	25 days	£2.81
2nd	Budesonide 64mcg (Rhinocort Aqua®) 120 doses <i>Also licensed for nasal polyps</i>	Adults and children over 12: two sprays into each nostril once a day, or one spray into each nostril twice a day, reduce when symptoms controlled <i>NOTE: 33% systemic bioavailability</i>	£4.77 (120 doses)	POM	30 days	£4.45
2nd	Fluticasone furoate 27.5 mcg (Avamys®) 120 doses	Adults and children over 12: two sprays each nostril once daily, reduce when symptoms controlled <i>NOTE: <0.5% systemic bioavailability</i>	£6.44 (120 doses)	POM	30 days	£6.01
3rd	Fluticasone propionate and azelastine 137 micrograms / 50 micrograms (Dymista®)	Adults and children over 12: one actuation in each nostril twice daily (morning and evening). <i>NOTE: Low systemic bioavailability</i>	£14.80 (120 doses)	POM	30 days	£13.81
3rd	Fluticasone propionate nasule drops 400mcg <i>licensed for nasal polyps only</i> Expensive option.	Adults and children over 16: The contents of one container (400 micrograms) to be instilled once or twice daily. The dose should be divided between the affected nostrils. <i>NOTE: Systemic bioavailability is extremely low (mean 0.06 %).</i>	£12.99 (28)	POM	14 or 28 days	£12.99 (OD) £25.98 (BD)
Antihistamine Nasal Sprays						
1st	Azelastine 140mcg (Rhinolast®) 157 sprays	Adults and children over 12: one spray into each nostril twice a day	£10.50	POM	39 days	£7.53
Watery Rhinorrhoea						
1st	Ipratropium 0.03% Nasal spray 21 mcg/ spray (Rinatec®)	Adults and children over 12: Two sprays each nostril 2-3 times a day	£6.54 (180 doses)	POM	15 days	£12.20
Oral Antihistamine –Non sedating (may be low incidence of sedation) Adults and child >6						
1st	Cetirizine 10mg tablets	Adults and Children over 12: 10mg once a day	73p	P/GSL	30 days	73p
1st	Loratadine 10mg tablets	Adults and Children over 12: 10mg once a day	65p	P/GSL	30 days	65p

Useful resources for patients:

Patient information on how to use nose drops correctly: <https://patient.info/health/allergies/features/how-to-use-nose-drops>

Patient information on how to use nose spray correctly: <https://patient.info/health/steroid-nasal-sprays>

Patient information on how to use Flixonase nasules: <https://www.medicines.org.uk/EMC/medicine/4332/PIL/Flixonase+Nasule+Drops/>

References:

Allergic Rhinitis NICE Clinical Knowledge Summaries October 2015. <https://cks.nice.org.uk/allergic-rhinitis>

BSACI guideline for the diagnosis and management of allergic and non-allergic rhinitis (Revised Edition 2017). Skadding G K et al. Clinical & Experimental Allergy 47; 7 July 2017 (p856–889) <http://onlinelibrary.wiley.com/doi/10.1111/cea.12953/full>